

1970

CERTIFICATE OF DEATH

1973

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Kent</u>	
3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. LENGTH OF STAY IN 1b <u>38 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Kent &amp; Queen Anne Co. Hosp</u>		1d. STREET ADDRESS <u>Piney Neck</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>J.</u> Last <u>Baker</u>		4. DATE OF DEATH Month <u>2</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-22-1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fishing</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>219-07-6780</u>	
17. INFORMANT <u>Wife Mary C Baker - Rock Hall Md</u>		Address <u>Wife</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>38 days</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Advanced Age</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/18/59</u> , 19 <u>59</u> , to <u>2/25/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/25/59</u> , 19 <u>59</u> , and that death occurred at <u>5:10</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William M. Salmon</u> M.D.		ADDRESS (Street, city or town, state) <u>Rock Hall, MD</u> DATE SIGNED <u>2/25/59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 28, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wishy Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Rock Hall Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin V. Williams - Chestertown, Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 2 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1970

1. NAME OF DECEASED [Name]		2. SEX [Male/Female]		3. AGE [Age]	
4. DATE OF DEATH [Date]		5. TIME OF DEATH [Time]		6. PLACE OF DEATH [Place]	
7. CAUSE OF DEATH [Cause]		8. MANNER OF DEATH [Manner]		9. PLACE OF BIRTH [Place]	
10. OCCUPATION [Occupation]		11. EDUCATION [Education]		12. MARITAL STATUS [Status]	
13. PREVIOUS ILLNESS [Illness]		14. MEDICAL HISTORY [History]		15. SURVIVAL OF SURVIVORS [Survivors]	
16. SIGNATURE OF PHYSICIAN [Signature]		17. SIGNATURE OF REGISTRAR [Signature]		18. SIGNATURE OF WITNESS [Signature]	
19. DATE OF SIGNATURE [Date]		20. TIME OF SIGNATURE [Time]		21. PLACE OF SIGNATURE [Place]	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD, AND A COPY IS TO BE FURNISHED TO THE FAMILY OF THE DECEASED.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1985

CERTIFICATE OF DEATH

01974

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Galena</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Galena</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM V. BANKS</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>1,</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 15, 1884</b>		9. AGE (In years last birthday) yrs. <b>74</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Wilm. Del.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Banks</b>				14. MOTHER'S MAIDEN NAME <b>Esther Harris</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Martha Banks,</b> Address <b>Galena, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of the Maxilla</b> <b>1960</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Senile debility.</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>one year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 6, 1958</b> to <b>Jan 28, 1959</b> , that I last saw the deceased alive on <b>Jan 28, 1959</b> , and that death occurred at <b>G.P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>MILLINGTON</b> DATE SIGNED <b>2-3-59</b> ACTUAL SIGNATURE <b>J. K. Kralewski</b> M.D. PHYSICIAN'S NAME (Type) <b>W. A. KORALEWSKI</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 5, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Olivet Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rural Galena, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward J. Holloway</b> ADDRESS <b>Millington, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 6 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
SM 2/57

1  
Items 18-21 Film 239 2-19-59  
1971  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01975

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN lb <b>lifetime</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>37 Chestertown</b> d. STREET ADDRESS <b>224 Kent St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Roy B. Barnett</b>		4. DATE OF DEATH <b>Feb. 3, 1959</b> Month Day Year	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9/15/1898</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Starkey Farms</b>	
11. BIRTHPLACE (State or foreign country) <b>Kent Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Vernor M. Vernor M. Barnett</b>		14. MOTHER'S MAIDEN NAME <b>Edna Sheats</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>070-03-1941</b>	
17. INFORMANT <b>Mrs. Edna Barnett</b> Address <b>Kent St. Chestertown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>at present undetermined. Negative autopsy</b> <b>970.8</b> DURING LAST ILLNESS (b) <b>findings: Blood, brain, liver, kidney tissues &amp; gastric contents being studied for toxicology.</b> CONDITIONS, if any, which gave rise to immediate cause (c) <b>Seen by Dr. shortly before death. Had been unconscious at least 24 hrs. Empty bottle of sleeping pills by bedside.</b> DUE TO <b>Petechial hemorrhages to brain, inactive Pulmonary TBC</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. <b>2/2/59</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>		20f. (City or town) (County) (State) <b>Chestertown Kent Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <b>R. W. Farr</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Robert W. Farr</b>		DATE SIGNED <b>2/3/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/6/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b> ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 5 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kraus</b>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

NAME OF DECEASED  
(Print Name)

RESIDENCE  
(Print Name and Address)

DATE OF DEATH  
(Month, Day, Year)

PLACE OF DEATH  
(Print Name and Address)

SEX  
(Male or Female)

AGE  
(In Years and Months)

DATE OF BIRTH  
(Month, Day, Year)

NO. OF THIS CERTIFICATE  
(Print Number)

CAUSE OF DEATH  
(Print Name and Address)

PLACE OF DEATH  
(Print Name and Address)

DATE OF DEATH  
(Month, Day, Year)

PLACE OF DEATH  
(Print Name and Address)

DATE OF DEATH  
(Month, Day, Year)

PLACE OF DEATH  
(Print Name and Address)

DATE OF DEATH  
(Month, Day, Year)

PLACE OF DEATH  
(Print Name and Address)

DATE OF DEATH  
(Month, Day, Year)

PLACE OF DEATH  
(Print Name and Address)



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**1986**

**CERTIFICATE OF DEATH**

01976

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Kent</u> <span style="float:right">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> <span style="float:right">b. COUNTY <u>Kent</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown (Rural)</u>				c. LENGTH OF STAY IN 1b <u>25 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent &amp; Queen Anne's</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Chestertown, (Rural)</u>		f. STREET ADDRESS  	
g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Walter Philip Bloecher</u>				<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>19</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 26, 1889</u>	
9. AGE (In years last birthday) <u>69 yrs.</u>		IF UNDER 1 YEAR: Months <u>69</u> Days <u>69</u> Hours <u>69</u> Min. <u>69</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY  		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Theodore Bloecher</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Both</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Under XX</u> <u>yes WW 1</u>				16. SOCIAL SECURITY NO. <u>179-03-0110</u>		17. INFORMANT <u>Mrs. Walter Bloecher, Chestertown, Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> Years <u>420.1</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>58</u> to <u>February</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>19 February</u> , 19 <u>59</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>203 North Queen Street</u> DATE SIGNED <u>2/20/9</u> ACTUAL SIGNATURE <u>Harry Paul Ross</u> M.D. PHYSICIAN'S NAME (Type) <u>HARRY PAUL ROSS, M.D.</u> <u>Chestertown, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/22/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St/ Paul Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>near - Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u> <u>Chestertown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaud</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1972

## CERTIFICATE OF DEATH

Reg. Dist. No.

01977

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown, Md.</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>At home</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Water St.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Philip Medford Brooks</b>		4. DATE OF DEATH Month Day Year <b>Feb. 23, 1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/29/1885</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Feed Mill &amp; Grain</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Kent Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Philip A. Brooks</b>		14. MOTHER'S MAIDEN NAME <b>Susan Massey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-32-0247</b>	
17. INFORMANT <b>P. M. Brooks, Jr.</b>		Address <b>Chestertown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Leaking Aneurism - abdominal aorta</b> <b>451X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Aneurism Abdominal aorta</b> DUE TO <b>Arterio sclerotic cardio vascular disease</b> (c) <b>don't Know</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>6 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19 50</b> to <b>Feb. 23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Feb. 23</b> , 19 <b>59</b> , and that death occurred at <b>4:30</b> A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert W. Farr</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>Chestertown, Md. Feb. 24, 1959</b>	
PHYSICIAN'S NAME (Type) <b>Robert W. Farr</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 25, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>I.U. Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>near - Worton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Willis Wells</b>		ADDRESS <b>Chestertown, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE FEB 25 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

CERTIFICATE OF DEATH

1912

For Death

Place of Birth

Age

Sex

Color

Married

Single

Occupation

Residence

Cause of Death

Immediate Cause

Underlying Cause

Time of Death

Place of Death

Signature of Physician

Signature of Registrar

Death - Cause

Death - Location - Hospital or Home

Death - Time

Death - Place

Death - Cause

Death - Location

Death - Time

Death - Cause

Death - Location

Death - Time

Death - Cause

Death - Location

Death - Time

Death - Cause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1973

## CERTIFICATE OF DEATH

01978

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNES.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>INGLETSIDE</u> 17X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>KENT &amp; QUEEN ANNES</u>		d. STREET ADDRESS <u>NONE</u>	
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>P.</u> Last <u>CONLEY</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 11, 1870</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(RET.) FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES H. CONLEY</u>		14. MOTHER'S MAIDEN NAME <u>LYDIA MOORE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>HOSPITAL CHART.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>156.1 METASTATIC CARCINOMA OF LIVER</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-28</u> , 19 <u>59</u> , to <u>2-6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2-5</u> , 19 <u>59</u> , and that death occurred at <u>7 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>CHESTERTOWN, Md</u> DATE SIGNED <u>2-1</u>			
ACTUAL SIGNATURE <u>Arthur J. Keffe</u> M.D.			
PHYSICIAN'S NAME (Type) <u>A. T. KEEFE JR. M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>2/9/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Templeville</u>		22d. LOCATION (City, town, or county) (State) <u>Templeville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulaie's Greensboro, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 9 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur J. Keffe</u>			

CERTIFICATE OF DEATH

1933

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. PLACE OF DEATH		9. DATE OF DEATH		10. TIME OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. PLACE OF INTERMENT		14. DATE OF INTERMENT		15. TIME OF INTERMENT	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	
21. SIGNATURE OF CLERK		22. SIGNATURE OF CHIEF CLERK		23. SIGNATURE OF ASSISTANT CLERK		24. SIGNATURE OF DEPUTY CLERK		25. SIGNATURE OF CLERK	
26. SIGNATURE OF CLERK		27. SIGNATURE OF CHIEF CLERK		28. SIGNATURE OF ASSISTANT CLERK		29. SIGNATURE OF DEPUTY CLERK		30. SIGNATURE OF CLERK	
31. SIGNATURE OF CLERK		32. SIGNATURE OF CHIEF CLERK		33. SIGNATURE OF ASSISTANT CLERK		34. SIGNATURE OF DEPUTY CLERK		35. SIGNATURE OF CLERK	
36. SIGNATURE OF CLERK		37. SIGNATURE OF CHIEF CLERK		38. SIGNATURE OF ASSISTANT CLERK		39. SIGNATURE OF DEPUTY CLERK		40. SIGNATURE OF CLERK	
41. SIGNATURE OF CLERK		42. SIGNATURE OF CHIEF CLERK		43. SIGNATURE OF ASSISTANT CLERK		44. SIGNATURE OF DEPUTY CLERK		45. SIGNATURE OF CLERK	
46. SIGNATURE OF CLERK		47. SIGNATURE OF CHIEF CLERK		48. SIGNATURE OF ASSISTANT CLERK		49. SIGNATURE OF DEPUTY CLERK		50. SIGNATURE OF CLERK	
51. SIGNATURE OF CLERK		52. SIGNATURE OF CHIEF CLERK		53. SIGNATURE OF ASSISTANT CLERK		54. SIGNATURE OF DEPUTY CLERK		55. SIGNATURE OF CLERK	
56. SIGNATURE OF CLERK		57. SIGNATURE OF CHIEF CLERK		58. SIGNATURE OF ASSISTANT CLERK		59. SIGNATURE OF DEPUTY CLERK		60. SIGNATURE OF CLERK	
61. SIGNATURE OF CLERK		62. SIGNATURE OF CHIEF CLERK		63. SIGNATURE OF ASSISTANT CLERK		64. SIGNATURE OF DEPUTY CLERK		65. SIGNATURE OF CLERK	
66. SIGNATURE OF CLERK		67. SIGNATURE OF CHIEF CLERK		68. SIGNATURE OF ASSISTANT CLERK		69. SIGNATURE OF DEPUTY CLERK		70. SIGNATURE OF CLERK	
71. SIGNATURE OF CLERK		72. SIGNATURE OF CHIEF CLERK		73. SIGNATURE OF ASSISTANT CLERK		74. SIGNATURE OF DEPUTY CLERK		75. SIGNATURE OF CLERK	
76. SIGNATURE OF CLERK		77. SIGNATURE OF CHIEF CLERK		78. SIGNATURE OF ASSISTANT CLERK		79. SIGNATURE OF DEPUTY CLERK		80. SIGNATURE OF CLERK	
81. SIGNATURE OF CLERK		82. SIGNATURE OF CHIEF CLERK		83. SIGNATURE OF ASSISTANT CLERK		84. SIGNATURE OF DEPUTY CLERK		85. SIGNATURE OF CLERK	
86. SIGNATURE OF CLERK		87. SIGNATURE OF CHIEF CLERK		88. SIGNATURE OF ASSISTANT CLERK		89. SIGNATURE OF DEPUTY CLERK		90. SIGNATURE OF CLERK	
91. SIGNATURE OF CLERK		92. SIGNATURE OF CHIEF CLERK		93. SIGNATURE OF ASSISTANT CLERK		94. SIGNATURE OF DEPUTY CLERK		95. SIGNATURE OF CLERK	
96. SIGNATURE OF CLERK		97. SIGNATURE OF CHIEF CLERK		98. SIGNATURE OF ASSISTANT CLERK		99. SIGNATURE OF DEPUTY CLERK		100. SIGNATURE OF CLERK	

TO PRESENT TO THE REGISTRAR OF DEATHS

1974

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>Chestertown</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Centreville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Centreville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne's Hospital</b>		d. STREET ADDRESS <b>Centreville</b>	
3. NAME OF DECEASED (Type or print) First <b>Arey</b> Middle <b>Potts</b> Last <b>Dorrell</b>		4. DATE OF DEATH Month <b>2/</b> Day <b>28</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/12/1888</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR: Months <b>70</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Centreville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>William Potts</b>		14. MOTHER'S MAIDEN NAME <b>Mary Stant</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Francis Middleton</b>		Address <b>Daughter Of Hospital Chart</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke</b> <b>433.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Auricular fibrillation</b> DUE TO (c) <b>8 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>8 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cholelithiasis</b> <b>Diabetes Mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/19</b> , 19 <b>59</b> , to <b>2/28</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>2/28</b> , 19 <b>59</b> , and that death occurred at <b>9:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>2/28/59</b>			
ACTUAL SIGNATURE <b>Robert W. Farr</b>		M.D. <b>Chestertown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Robert W. Farr, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>MAR 3, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Chester Field Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Centreville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Butler Jr. of Butler Bros., Centreville, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAR 5 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinn</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED [Handwritten: John Doe]		SEX [Handwritten: Male]		AGE [Handwritten: 45]	
DATE OF DEATH [Handwritten: Jan 15, 1925]		TIME OF DEATH [Handwritten: 10:30 AM]		PLACE OF DEATH [Handwritten: Home]	
CAUSE OF DEATH [Handwritten: Heart Disease]		MANNER OF DEATH [Handwritten: Natural]		PLACE OF BURIAL [Handwritten: St. Mary's Cemetery]	
NAME OF PHYSICIAN [Handwritten: Dr. J. Smith]		NAME OF FUNERAL HOME [Handwritten: Johnson & Co.]		NAME OF UNDERTAKER [Handwritten: Johnson & Co.]	
NAME OF NEXT OF KIN [Handwritten: Mrs. Jane Doe]		NAME OF WITNESS [Handwritten: Dr. J. Smith]		NAME OF REGISTRAR [Handwritten: J. Doe]	
SIGNATURE OF PHYSICIAN [Handwritten: J. Smith]		SIGNATURE OF FUNERAL HOME [Handwritten: Johnson & Co.]		SIGNATURE OF UNDERTAKER [Handwritten: Johnson & Co.]	
SIGNATURE OF NEXT OF KIN [Handwritten: Mrs. Jane Doe]		SIGNATURE OF WITNESS [Handwritten: Dr. J. Smith]		SIGNATURE OF REGISTRAR [Handwritten: J. Doe]	

This certificate is to be filled out by the physician or the funeral home, and is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland. It is to be kept for a period of ten years.

The Registrar of the State Department of Health, Baltimore, Maryland, is to be notified of the death of a person by the physician or the funeral home, and is to be furnished with a copy of this certificate.

The Registrar of the State Department of Health, Baltimore, Maryland, is to be notified of the death of a person by the physician or the funeral home, and is to be furnished with a copy of this certificate.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1

1975

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 13 FilmG239 2-20-59 et  
CERTIFICATE OF DEATH

Reg. Dist. No.

019811

1. PLACE OF DEATH o. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WORTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENT &amp; QUEEN ANNE'S HOSP</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HESTER OLIVIA HADAWAY</u>				4. DATE OF DEATH Month Day Year <u>FEB 17 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 7 1895</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>WILLIAM HOLDEN Carroll</u>				14. MOTHER'S MAIDEN NAME <u>MARY MCCAULEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>215-20-0111</u>		17. INFORMANT <u>HOSP. CHART</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>FRACTURES, LEFT HIP &amp; LEFT FOREARM</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 HRS.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>FEB 2, 1959</u> , to <u>FEB 17, 1959</u> , that I last saw the deceased alive on <u>FEB 17, 1959</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>CHESTERTOWN, MD.</u> DATE SIGNED <u>FEB 17, 59</u>							
ACTUAL SIGNATURE <u>A. T. Keefe</u> M.D.		PHYSICIAN'S NAME (Type) <u>A. T. KEEFE, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2-20-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>UNION CEMETERY</u>	22d. LOCATION (City, town, or county) <u>WORTON, MD.</u>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u> ADDRESS <u>STILL POND, MD.</u>			24a. REC'D BY REGISTRAR <u>FEB 19 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kennedy</u>			



1975

# CERTIFICATE OF DEATH

0198

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>KENT</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>KENT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTERTOWN</b>		c. LENGTH OF STAY IN 1b <b>27 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENT &amp; QUEEN ANNE'S HOSP</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ANNA ELIZA JACQUETTE</b>		4. DATE OF DEATH Month <b>FEB</b> Day <b>22</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 20, 1882</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MD</b>	
11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ISAAC SIMMS</b>		14. MOTHER'S MAIDEN NAME <b>HARRIET ANN CRANER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>HOSP CHART</b>	
17. INFORMANT <b>HOSP CHART</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of left Ovary</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 wks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN 26, 1959</b> , to <b>FEB 22, 1959</b> , that I last saw the deceased alive on <b>FEB 22, 1959</b> , and that death occurred at <b>9:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>CHESTERTOWN, MD</b> DATE SIGNED <b>2/22/59</b> ACTUAL SIGNATURE <b>A. T. KEEFE, JR. M.D.</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/25/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Chester</b>		22d. LOCATION (City, town, or county) (State) <b>Chestertown MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar E. Sam</b>		24a. REC'D BY REGISTRAR <b>FEB 27 '59</b>	
ADDRESS <b>Church Hill</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. King</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55





## CERTIFICATE OF DEATH

Reg. Dist. No.

01982

1977

1. PLACE OF DEATH o. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ches tertown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>37 Chestertown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Annes</b>				d. STREET ADDRESS <b>1 208 Gross St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Anthony Samuel Johnson</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>3</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 28 1958</b>		9. AGE (In years last birthday) yrs. <b>2</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>5</b> Hours <b>5</b> Min. <b>5</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Is aiah Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Carolyn Wic kes</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>mother &amp; hospital records, Chestertown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/28</b> , 19 <b>58</b> , to <b>2/3/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>2/3/59</b> , 19 <b>59</b> , and that death occurred at <b>8:15A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chestertown, Md.</b> DATE SIGNED <b>2/3/59</b>							
ACTUAL SIGNATURE <b>Robert W. Farr</b>		M.D. <b>Chestertown, Md.</b>					
PHYSICIAN'S NAME (Type) <b>ROBERT W. FARR</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/4/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Broad Neck Cem. near Chestertown, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Zametha Walker</b>				ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 5 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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01983

1978

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>				c. LENGTH OF STAY IN 1b <b>3 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne's (6 days)</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>Virginia</b> Last <b>Kaufman</b>				4. DATE OF DEATH Month <b>February</b> Day <b>17</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b> <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 14, 1916</b>	
9. AGE (In years last birthday) <b>42 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>James L. Teat</b>				14. MOTHER'S MAIDEN NAME <b>Mildred N. Horney</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes</b>		17. INFORMANT <b>deceased</b> Address <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction with congestive failure</b> <b>292.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hemolytic anemia (Probably congenital)</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1. Obesity, marked</b> <b>2. Probably diabetes mellitus</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-22</b> , <b>19-59</b> , to <b>2-17</b> , <b>19-59</b> , that I last saw the deceased alive on <b>2-17</b> , <b>19-59</b> , and that death occurred at <b>11:55 p.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>203 North Queen Street</b> DATE SIGNED <b>2-18-59</b>							
ACTUAL SIGNATURE <b>HARRY PAUL ROSS</b> PHYSICIAN'S NAME (Type) <b>HARRY PAUL ROSS</b>				M.D. <b>203 North Queen Street</b> <b>Chestertown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/21/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Willis Wells</b> ADDRESS <b>Chestertown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Catherine E. Horney</b>	

MEDICAL CERTIFICATION

72

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1979

## CERTIFICATE OF DEATH

Reg. Dist. No.

01984

1. PLACE OF DEATH o. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>QUEEN ANNE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millington, R.D.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent and Queen Anne Hospital</b>		d. STREET ADDRESS <b>17X-2</b>	
3. NAME OF DECEASED (Type or print) First <b>WAYNE</b> Middle <b>EDWARD</b> Last <b>LEAGER</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>16,</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 4, 1958</b>
9. AGE (In years lost birthday) yrs. <b>21</b>		IF UNDER 1 YEAR: Months <b>4</b> Days <b>16</b> Hours <b>16</b> Min. <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baby</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baby None</b>	
11. BIRTHPLACE (State or foreign country) <b>Kent, Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Earl F. Leager</b>		14. MOTHER'S MAIDEN NAME <b>Mary M. Loffland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Mary Leager, Millington, Md. R.D.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Staphylococcus Bronchitis Pneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 Wk</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/14</b> , 19 <b>59</b> , to <b>2/16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>2/14</b> , 19 <b>59</b> , and that death occurred at <b>2:30</b> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chestertown MD</b> DATE SIGNED <b>2/16/59</b> ACTUAL SIGNATURE <b>Thomas J. Solan</b> M.D. PHYSICIAN'S NAME (Type) <b>THOMAS J. SOLAN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 18, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Double Creek Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Crumpton, Rural, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Bellows Millington Md.</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 20 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

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1980

## CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="float: right;"><b>MARYLAND</b></span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <span style="float: right;"><b>Maryland</b></span> b. COUNTY <span style="float: right;"><b>Queen Annes</b></span>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN 1b 	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Annes</b>		d. STREET ADDRESS <b>11 Walnut Street</b>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Ethel</b> Middle <b>May</b> Last <b>Merrick</b>		<b>4. DATE OF DEATH</b> Month <b>February</b> Day <b>16</b> Year <b>1959</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>May 25, 1880</b>
<b>9. AGE</b> (In years last birthday) <b>78</b> yrs.		<b>10. IF UNDER 1 YEAR</b> IF UNDER 24 HRS. Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Queen Annes</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>William D. Smith</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Fannie Walls</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>213-03-5005</b>	
<b>17. INFORMANT</b> <b>JBT Merrick (husband)</b>		<b>Address</b> <b>Church Hill, Md.</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>Probable Hepatitis</b> <b>583X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Diabetes Mellitus</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 days</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour o. p. m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that I attended the deceased from</b> <b>2/1/59</b> , 19____, to <b>2/16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>2/16/59</b> , 19____, and that death occurred at <b>8:30 P.M.</b> , from the causes and on the date stated above.			
<b>ACTUAL SIGNATURE</b> <i>Robert W. Farr</i> M.D.		<b>ADDRESS</b> (Street, city or town, state) <b>Chesertown, Md.</b>	
<b>PHYSICIAN'S NAME (Type)</b> <b>Robert W. Farr</b>		<b>DATE SIGNED</b> <b>2/16/59</b>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>22b. DATE THEREOF</b> <b>Feb 19-59</b>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Church Hill</b>	<b>22d. LOCATION</b> (City, town, or county) (State) <b>Church Hill Maryland</b>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>W. James Baiton</i>		<b>ADDRESS</b> <b>Baiton Bros Centerville Maryland</b>	<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>FEB 19 1959</b>
<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Hines</i>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VS A15 (4)  
15M 9/55



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 1

1981

## CERTIFICATE OF DEATH

Reg. Dist. No.

1986

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN 1b <b>38 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne's</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RD#2 Chestertown</b>	
3. NAME OF DECEASED (Type or print) First <b>Mina</b> Middle <b>A</b> Last <b>Newcomb</b>		4. DATE OF DEATH Month <b>Feb</b> Day <b>8</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cau White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 Feb 1876</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
12. BIRTHPLACE (State or foreign country) <b>Maryland</b>		13. CITIZEN OF WHAT COUNTRY? <b>US</b>	
14. FATHER'S NAME <b>Emmel Reiche</b>		15. MOTHER'S MAIDEN NAME <b>Unknown</b>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		17. SOCIAL SECURITY NO. <b>None</b>	
18. INFORMANT <b>Ellsworth T. Newcomb</b>		Address <b>RD#2 Chestertown, Maryland</b>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart block, complete</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-13</b> , 19 <b>59</b> , to <b>2-7</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>2-7</b> , 19 <b>59</b> , and that death occurred at <b>1:20a</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>HARRY PAUL ROSS</b>		M.D. <b>203 North Queen Street</b>	
PHYSICIAN'S NAME (Type) <b>HARRY PAUL ROSS, M.D.</b>		<b>Chestertown, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/10/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Still Pond</b>		22d. LOCATION (City, town, or county) (State) <b>Still Pond Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows</b>		ADDRESS <b>Millington, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE FEB 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1982 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01987

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN 1b <b>life</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert St.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>37 Chestertown</b> d. STREET ADDRESS <b>Calvert St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Edward Robinson</b>		4. DATE OF DEATH <b>Feb. 15, 1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 3, 1930</b>
9. AGE (In years last birthday) <b>29</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Kent Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Percy Robinson</b>		14. MOTHER'S MAIDEN NAME <b>Florence Gland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-24-4090</b>	
17. INFORMANT <b>Mrs. Florence Robinson</b>		Address <b>Chestertown, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Internal hemorrhage and cardiac tamponade</b> DUE TO (b) <b>Bullet wound perforating right ventricle,</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <b>descending aorta, vena cava, and right pulmonary artery</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hemorrhage - rt lower lobe of lung thru which bullet wound</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <b>trauma passed Homicide</b>			
20a. TIME OF INJURY Month, Day, Year <b>10:45 2/15/59</b>		20b. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20d. (City or town) (County) (State) <b>Chestertown Kent Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Robert W. Farr</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Robert W. Farr, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>2/19/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 19, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Janes Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth Waller</b>		ADDRESS <b>Chestertown, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible] RACE: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

IMMEDIATE CAUSE OF DEATH: [illegible]

UNDERLYING CAUSE OF DEATH: [illegible]

DATE OF EXAMINATION: [illegible] BY: [illegible]

SIGNATURE OF EXAMINER: [illegible]

DATE OF SIGNATURE: [illegible]

PLACE OF SIGNATURE: [illegible]

REMARKS: [illegible]

DATE OF REMARKS: [illegible]

BY: [illegible]

DATE OF BY: [illegible]

PLACE OF BY: [illegible]

SIGNATURE OF BY: [illegible]

DATE OF SIGNATURE OF BY: [illegible]

PLACE OF SIGNATURE OF BY: [illegible]

SIGNATURE OF BY: [illegible]

DATE OF SIGNATURE OF BY: [illegible]

PLACE OF SIGNATURE OF BY: [illegible]

1  
FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1983 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01988

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>37 Chestertown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Chester River</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Addie Hurlock Usilton</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>24</b> Year <b>1959</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 10 1895</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Kent Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Hurlock</b>		14. MOTHER'S MAIDEN NAME <b>Addelle Skirven</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Fred G. Usilton Jr. Denton, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> <b>975x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Short time</b>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Jumped or fell into Chester River</b>	
20c. TIME OF INJURY Month, Day, Year <b>6 Hour 8 30AM 2/24/59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Chester River Chestertown</b>		20f. (City or town) (County) (State) <b>Kent Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Robert W. Farr</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>February 25, 1959</b>	
EXAMINER'S NAME (Type) <b>Robert W. Farr</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 26/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Marvin V. Williams</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 2 1959</b>	
ADDRESS <b>Chestertown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



Reg. Dist. No. 01989

1984

1. PLACE OF DEATH a. COUNTY <b>Kent</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN lb <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>108 College Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HENRY WHITE</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>12</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/1/ 1896</b>
9. AGE (In years last birthday) yrs. <b>63</b>		10. IF UNDER 1 YEAR: Months <b>63</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		12. KIND OF BUSINESS OR INDUSTRY <b>farm</b>	
13. BIRTHPLACE (State or foreign country) <b>Kent. Co. Md.</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. FATHER'S NAME <b>henry white</b>		16. MOTHER'S MAIDEN NAME <b>Harriet White</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		18. SOCIAL SECURITY NO. <b>213-18-4923</b>	
19. INFORMANT <b>Joseph Goulden</b>		20. ADDRESS <b>108 College Ave Chestertown, Md.</b>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>422.1</b> DUE TO <b>Arterio sclerotic cardio vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>don't know</b> DUE TO (c) <b>several years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>several years</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		22b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Chestertown, Md.</b>	
22c. (City or town) <b>Chestertown</b>		22d. (County) <b>Kent</b>	
22e. (State) <b>Md.</b>		22f. (City or town) <b>Chestertown</b>	
23. I certify that I attended the deceased from <b>Jan. 26</b> , 19 <b>59</b> , to <b>Feb. 12</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Feb. 12</b> , 19 <b>59</b> , and that death occurred at <b>6:00A</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert W. Farr</b>		DATE SIGNED <b>2/12/59</b>	
PHYSICIAN'S NAME (Type) <b>Robert W. Farr, M. D.</b>		ADDRESS (Street, city or town, state) <b>Chestertown, Md.</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE THEREOF <b>2/13/59</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Chestertown Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>Marvin V. Williams</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 16 '59</b>	
25b. REGISTRAR'S SIGNATURE <b>Marvin V. Williams</b>		25c. DATE <b>2/16/59</b>	

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55



